

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

| | |
|---|---|
| Type of Requestor: (x) HCP () IE () IC | Response Timely Filed? (x) Yes () No |
| Requestor's Name and Address Community Rehabilitation & Work Conditioning 433 W. 12 th St. Dallas, TX 75208 | MDR Tracking No.: M4-04-4374-01 |
| | TWCC No.: |
| | Injured Employee's Name: |
| Respondent's Name and Address Dallas Area Rapid Transit Box 15 c/o ESIS Inc. for DART P.O. Box 152036 Irving, TX 75015 | Date of Injury: |
| | Employer's Name: Dallas Area Rapid Transit |
| | Insurance Carrier's No.: 00945001232 |

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

| Dates of Service | | CPT Code(s) or Description | Amount in Dispute | Amount Due |
|------------------|----------|----------------------------|-------------------|------------|
| From | To | | | |
| 06/09/03 | 07/15/03 | 97545-WC & 97546-WC | \$2,570.00 | \$1,036.80 |
| | | | | |

PART III: REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position summary; however, the Requestor's Rationale on the Table of Disputed Services states that services were preauthorized.

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent's position summary states in part, "...Based on the opinions of Dr. Beavers and Dr. Taba the claimant's problems stemmed from her pre-existing arthritis and not the torn meniscus that was repaired and healed, per the peer review from Dr. Blanchette no further treatment based on her review would be considered medically reasonable or necessary to the compensable injury."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

On April 4, 2005 a Benefit Review Conference was held. The parties agreed that the compensable injury includes a torn meniscus or the right knee, and that the compensable injury does not include arthritis or a degenerative condition of the right knee.

On December 15, 2003 the health care provider submitted a dispute for non-payment of preauthorized services. The HCFA-1500's submitted with the dispute listed the diagnosis codes of 836.0 – Tear of medial cartilage or meniscus of knee, current; 844.8 – Other specified sites of knee and leg; and 959.7 – Knee. Leg, ankle, and foot. The health care provider did not submit any medical records documenting an arthritic or a degenerative condition of the right knee. Therefore, this dispute will be reviewed in accordance with the 1996 Medical Fee Guideline and TWCC Rules.

- CPT Code 97545-WC for dates of service 06/09/03 through 06/20/03 and 06/24/03 through 07/03/03. For date of service 06/20/03; although the health care provider has listed the amount paid was \$0.00, the submitted EOB has listed payment according to the MFG; therefore, this date of service is included as being paid. Per the 1996 MFG, Medicine Ground Rule (II)(C) the health care provider did not use the –AP modifier therefore the work conditioning program shall be reduced 20% below the maximum allowable reimbursement. The insurance carrier has made payment according to the MFG; therefore, additional reimbursement is not recommended.
- CPT Code 97546-WC for dates of service 06/09/03 through 06/20/03 and 06/24/03 through 07/03/03. For date of service 06/20/03; although the health care provider has listed the amount paid was \$0.00, the submitted EOB has listed payment according to the MFG; therefore, this date of service is included as being paid. Per the 1996 MFG, Medicine Ground Rule (II)(C) the health care provider did not use the –AP modifier therefore the work conditioning program shall be reduced 20% below the maximum allowable reimbursement. The insurance carrier has made payment according to the MFG; therefore, additional reimbursement is not recommended.
- CPT Code 97545-WC for dates of service 06/23/03 and 07/07/03 through 07/15/03 (10 hours). Neither party submitted EOBs for these dates of service. Per Rule 133.307(e)(2)(B) the Requestor has submitted convincing evidence of a request for reconsideration; therefore, these dates of service will be reviewed according to the 1996 MFG. Per the 1996 MFG, Medicine Ground Rule (II)(C) and (D)(2) submitted SOAP notes support the services were rendered as billed. Reimbursement in the amount of \$288.00 (\$36.00 x 80% = \$28.80 per hour x 10 hours) is recommended.

- CPT Code 97546-WC for dates of service 06/23/03 and 07/07/03 through 07/15/03 (26 hours). Neither party submitted EOBs for these dates of service. Per Rule 133.307(e)(2)(B) the Requestor has submitted convincing evidence of a request for reconsideration; therefore, these dates of service will be reviewed according to the 1996 MFG. Per the 1996 MFG, Medicine Ground Rule (II)(C) and (D)(2) submitted SOAP notes support the services were rendered as billed. Reimbursement in the amount of \$748.80 ($\$36.00 \times 80\% = \28.80 per hour \times 26 hours) is recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of \$1,036.80. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Or

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

Ordered by:

Marguerite Foster

June 15, 2005

Authorized Signature

Typed Name

Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____